

SCHIZOAFFECTIVE DISORDER

DSM-IV

295.70 Schizoaffective disorder

This disorder emphasizes the temporal relationship of schizophrenic and mood symptoms and is used for conditions that meet the criteria for both schizophrenia and a mood disorder with psychotic symptoms lasting a minimum of 1 month. The clinical features must occur within a single uninterrupted period of illness (for some, this may be years or even decades) that is judged to last until the individual is completely recovered for a significant period of time, free of any significant symptoms of the disorder. In comparison with schizophrenia, schizoaffective disorder occurs more commonly in women than in men.

ETIOLOGICAL THEORIES

Psychodynamics

Refer to CPs: Schizophrenia, Major Depression, and Bipolar Disorder.

Biological

Refer to CPs: Schizophrenia, Major Depression, and Bipolar Disorder.

Recent studies suggest that schizoaffective disorder is a distinct syndrome resulting from a high genetic liability to both mood disorders and schizophrenia.

Family Dynamics

Refer to CPs: Schizophrenia, Major Depression, and Bipolar Disorder.

CLIENT ASSESSMENT DATA BASE

Neurosensory

Depressed mood (at least 2 wks); manic or mixed mood (at least 1 wk)

Pronounced manic and depressive features intermingled with schizophrenic features

Delusions and hallucinations for at least 2 wks (in absence of prominent mood symptoms)

Difficulty following a moving object with the eyes

Teaching/Learning

May report previous episode(s) and remission free of significant symptoms; usually begins in early adulthood (generally earlier than mood disorders)

Absence of substance use or general medical conditions that could account for symptoms

DIAGNOSTIC STUDIES

Refer to CPs: Schizophrenia, Major Depression, and Bipolar Disorder.

NURSING PRIORITIES

1. Provide protective environment; prevent injury.
2. Assist with self-care.
3. Promote interaction with others.
4. Identify resources available for assistance.
5. Support family involvement in therapy.

DISCHARGE GOALS

1. Signs of physical agitation are abating and no physical injury occurs.
 2. Improved sense of self-esteem, lessened depression, and elevated mood are noted.
 3. Approaches and socializes appropriately with others, individually and in group activities.
 4. Adequate nutritional intake is achieved/maintained.
 5. Client/family displays effective coping skills and appropriate use of resources.
 6. Plan in place to meet needs after discharge.
- (Refer to CPs: Schizophrenia, Major Depression, and Bipolar Disorder for other NDs that apply, in addition to the following.)

NURSING DIAGNOSIS

Risk Factors May Include:

[Possible Indicators:]

Desired Outcomes/Evaluation Criteria— Client Will:

VIOLENCE, risk for, directed at self/others

Depressed mood; feelings of worthlessness; hopelessness

Unsatisfactory parent/child relationship; feelings of abandonment by significant other(s)

Anger turned inward/directed at the environment

Punitive superego and irrational feelings of guilt

Numerous failures (learned helplessness)

Misinterpretation of reality

Extreme hyperactivity

History of previous suicide attempts; making direct/indirect statements indicating a desire to kill self/having a plan

Hallucinations; delusional thinking

Self-destructive behavior (hitting body parts against wall/furniture); destruction of inanimate objects

Temper tantrums/aggressive behavior; increased agitation and lack of control over purposeless movements

Vulnerable self-esteem

Express improved sense of well-being/self-concept.

Manage behavior and deal with anger appropriately.

Demonstrate self-control without harm to self or others.

ACTIONS/INTERVENTIONS

RATIONALE

Independent

Note direct statements of a desire to kill self; also note indirect actions indicating suicidal wish, (e.g., putting affairs in order, writing a will, giving away prized possessions; presence of hallucinations and delusional thinking; history of previous suicidal behavior/acts; statements of hopelessness regarding life situation).

Ask client directly if suicide has been considered/ planned and if the means are available to carry out the plan.

Provide a safe environment for client by removing potentially harmful objects from access (e.g., sharp objects; straps, belts, ties; glass items; smoking materials).

Assign to quiet unit, if possible.

Reduce environmental stimuli (e.g., private room, soft lighting, low noise level, and simple room decor).

Stay with the client/request client remain in staff view. Provide supervision as necessary.

Formulate a short-term verbal contract with the client stating that he or she will not harm self during specified period of time. Renegotiate contract as necessary.

Ask client to agree to seek out staff member/friend if thoughts of suicide emerge.

Encourage verbalization of honest feelings. Explore and discuss symbols of hope client can identify in own life.

Promote expression of angry feelings within appropriate limits. Provide safe method(s) of hostility release. Help client identify true source of anger, and work on adaptive coping skills for continued use.

Direct and indirect indicators of suicidal intent need to be attended to and addressed as being potentially acted on.

The risk of suicide is greatly increased if the client has developed a plan, and particularly if means exist to execute the plan.

Provides protection while treatment is being undertaken to deal with existing situation. Client's rationality is impaired, she or he may harm self inadvertently.

Unit milieu may be too distracting, increasing agitation and potential for loss of control.

In hyperactive state, client is extremely distractible, and responses to even the slightest stimuli are exaggerated.

Provides support and feelings of security as agitation grows and hyperactivity increases.

An attitude of acceptance of the client as a worthwhile individual is conveyed. Discussion of suicidal feelings with a trusted individual provides a degree of relief to the client. A contract gets the subject out in the open and places some of the responsibility for own safety on the client.

The suicidal client is often very ambivalent about own feelings. Discussion of these feelings with a trusted individual may provide assistance before the client experiences a crisis situation.

Because of elevated anxiety, client may need assistance to recognize presence of hope in life situations.

Depression and suicidal behaviors may be viewed as anger turned inward on the self, or anger may be expressed as hostile acting-out toward others. If this anger can be verbalized and/or released in a nonthreatening environment, the client may be able to resolve these feelings, regardless of the discomfort involved.

Orient client to reality, as required. Point out sensory/environmental misperceptions, taking care not to belittle client's fears or indicate disapproval of verbal expressions.

Spend time with the client on a regular schedule and provide frequent intermittent checks as indicated in response to client needs.

Provide structured schedule of activities that includes established rest periods throughout the day.

Provide physical activities as a substitute for purposeless hyperactivity (e.g., brisk walks, housekeeping chores, dance therapy, aerobics).

Observe for effectiveness and evidence of adverse side effects of drug therapy (e.g., anticholinergic [dry mouth, blurred vision], extrapyramidal [tremors, rigidity, restlessness, weakness, facial spasms]).

Collaborative

Administer medication, as indicated:

Neuroleptics, e.g., chlorpromazine (Thorazine);

Antidepressants, e.g., imipramine (Tofranil);

Antimaniacs, e.g., lithium (Eskalith, Lithobid);

Antipsychotics, e.g.: clozapine (Clozaril), risperidone (Risperdal), olanzapine (Zyprexa).

Prepare for/assist with electroconvulsive therapy (ECT).

Identify community resources including crisis center/hotline.

Elevated level of anxiety may contribute to distortions in reality. Client may need help distinguishing between reality and misperceptions of the environment.

Provides a feeling of safety and security, while also conveying the message, "I want to spend time with you because I think you are a worthwhile person."

Structured schedule provides feeling of security for the client. Additional rest promotes relaxation for the agitated client.

Physical exercise provides a safe and effective means of relieving pent-up tension.

Individual reactions to medications may vary, and early identification can assist with changes in dosage and/or drug choice, possibly preventing client from discontinuing drug therapy prematurely with potential loss of control.

Pharmacological interventions need to be directed at the presenting symptoms and used on a short-term basis. Antipsychotics may be effective in reducing the hyperactivity associated with mania. May be combined with lithium or antidepressants and then gradually withdrawn.

Allows the accumulation of the neurotransmitters norepinephrine and serotonin, potentiating their antidepressant effect. Useful after psychosis has cleared.

The exact mechanism of action of these drugs is unknown; however, they are thought to alter chemical transmitters in the CNS, reducing manic behavior.

Used for management of manifestations of psychosis. **Note:** Elderly clients tend to respond well to Risperdal.

May be indicated to alter mood until neuroleptics or antidepressants become effective. **Note:** Some research suggests this is the most effective treatment for some clients.

Support systems promote independence/provide help for dealing with suicidal thoughts/feelings. Having a concrete plan for seeking assistance during a crisis may discourage or prevent self-destructive behaviors.

NURSING DIAGNOSIS**May Be Related to:****Possibly Evidenced by:****Desired Outcomes/Evaluation Criteria—****Client Will:****SOCIAL ISOLATION**

Developmental regression

Depressed mood; feelings of worthlessness

Egocentric behaviors (which offend others and discourage relationships)

Delusional thinking

Fear of failure

Impaired cognition fostering negative view of self

Unresolved grief

Sad, dull affect

Absence of supportive significant other(s): family, friends, group

Uncommunicative/withdrawn behavior; absence of eye contact; seeking to be alone

Preoccupation with own thoughts; repetitive, meaningless actions

Assuming fetal position; catatonic behaviors

Verbalize willingness to be with others.

Spend time voluntarily with others, seek out group activities.

Develop 1:1 trust-based relationship.

ACTIONS/INTERVENTIONS**Independent**

Spend time with client. (This may mean sitting in silence for a while.)

Develop a therapeutic nurse-client relationship through frequent, brief contacts and an accepting attitude. Show unconditional positive regard.

Encourage attendance in group activities, after client feels comfortable in the 1:1 relationship. Nurse may need to attend with client the first few times to offer support. Accept client's decision to remove self from group situation if anxiety becomes too great.

Provide positive reinforcement for client's voluntary interactions with others.

Verbally acknowledge client's absence from any group activities.

RATIONALE

Nurse's presence helps improve client's perception of self as a worthwhile person.

The nurse's presence, acceptance, and conveyance of positive regard enhance the client's feeling of self-worth and facilitate trust and interaction with others.

The presence of a trusted individual provides emotional security for the client. Moving slowly into a more threatening activity and accepting client's decision to leave promotes self-trust and sense of control.

Enhances self-esteem and encourages repetition of desirable behaviors.

Knowledge that absence was noticed may reinforce the client's feelings of importance and self-worth.

Assist client to learn assertiveness techniques.

Knowledge of the appropriate use of assertive techniques could improve client's relationships with others.

Devise a plan of therapeutic activities and provide client with a written time schedule.

The depressed client needs structure because of the impairment in decision-making/problem-solving ability. A structured schedule provides security until the client can function independently.

Help client learn skills that may be used to approach others in a socially acceptable manner. Practice these skills through role-play, beginning with simple assignments (e.g., introduce self in safe environment).

With practice, these skills become easier in real-life situations, and client feels more comfortable performing them.

Limit group activities, when client is agitated. Help client to establish 1 or 2 close relationships.

Client's ability to interact with others is impaired. More security is felt in a 1:1 relationship that is consistent over time.

NURSING DIAGNOSIS

NUTRITION: altered, less than body requirements

May Be Related to:

Energy expenditure in excess of calorie intake
Refusal/inability to sit still long enough to eat meals
Lack of attention to/recognition of hunger cues

Possibly Evidenced by:

Lack of interest in food; weight loss
Pale conjunctiva and mucous membranes
Poor muscle tone/skin turgor
Amenorrhea
Abnormal laboratory findings (e.g., anemias, electrolyte imbalances)

**Desired Outcomes/Evaluation Criteria—
Client Will:**

Identify and formulate plan to meet individual dietary needs.
Demonstrate adequate intake to maintain individual nutritional balance/provide desired weight gain.
Display normalization of laboratory values and be free of signs of malnutrition.

ACTIONS/INTERVENTIONS

RATIONALE

Independent

Determine individual daily caloric requirement, considering body structure, height, and activity and realistic weight gain.

Important for the provision of adequate nutrition.

Have juice and snacks available at all times.

Nutritious intake is required on a regular basis to compensate for increased caloric requirements caused by hyperactivity.

Provide high-protein, high-calorie, nutritious finger foods and drinks that can be consumed on the run.

Client may have difficulty sitting still long enough to eat a meal because of hyperactive state. It is more likely that the client will consume food and drinks that can be carried around and eaten with little effort.

Maintain accurate record of intake, output, and calorie count.

Necessary to make an accurate nutritional assessment, identify individual needs, and maintain client safety.

Recommend weighing on a regular schedule as individually appropriate.

Helpful in evaluating therapeutic needs and effectiveness of treatment plan.

Determine client's dietary likes and dislikes.

Client is more likely to eat foods that are particularly enjoyed.

Pace or walk with client as finger foods are taken. As agitation subsides, sit with client during meals. Offer support and encouragement.

Presence of a trusted individual may provide feeling of security and decrease agitation. Encouragement and positive reinforcement increase self-esteem and foster repetition of desired behaviors.

Help client learn the importance of adequate nutrition and fluid intake.

Client may have inadequate or inaccurate knowledge regarding the contribution of good nutrition to overall wellness.

Collaborative

Consult with dietitian as indicated.

Helpful in establishing individual needs/program and provides educational opportunity.

Administer vitamin and mineral supplements, as indicated.

To improve and/or restore nutritional well-being.

Monitor laboratory values and report status/significant nutritional changes.

Provides an objective assessment of therapeutic needs/effectiveness.